Subject to the Approval of the Task Force

Corrected Minutes
Health Care Task Force
October 27, 2005
9:00 a.m.
Joint Finance-Appropriations Committee Room
Statehouse, Boise, Idaho

The meeting was called to order by cochairman Senator Dean Cameron at 9:20 a.m. Other committee members present were: Cochairman Representative Bill Deal, Senators Joe Stegner, Dick Compton, Tim Corder and Kate Kelly, and Representatives Max Black, Sharon Block, Gary Collins, Kathie Garrett and Margaret Henbest. Senator John Goedde was absent and excused.

Others in attendance were: Julie Taylor, Blue Cross of Idaho; Kent Kunz, Governor's Office; Duane Smith, Jim Guthrie and Seth Beal, Gem Plan; Janelle Reilly, Kate Vanden Broek and Corey Surber, St. Alphonsus Regional Medical Center; Martha Arcos, Congressman Otter's Office; Suzanne Schaefer, SBS Associates LLC; Molly Steckel, Idaho Medical Association; Craig Herzog; Bonnie Haines, Idaho Hospital Association; Ed Dahlberg, St. Luke's Regional Medical Center; Carl Hanson, Minidoka Memorial Hospital; Elwood Kleaver, Primary Health; Representative John Rusche; Scott Pugrud, Connolly and Smyser; Steve Farro, Digestive Health Clinic; Ike Tanabe; Kris Ellis, Benton and Associates; Woody Richards; Todd Lakey; and Kathy Pidjeon.

Senator Corder moved that the minutes from the last meeting be approved. **Senator Compton** seconded the motion; the minutes were approved unanimously by voice vote.

Mr. Laren Walker was introduced to give an update on the Idaho Individual High Risk Reinsurance Pool. He said his information compares August 31, 2005 to August 31, 2004. The information includes assets and liabilities of the high risk pool as well as revenues and expenditures. A copy of the chart is available at the Legislative Services Office.

Representative Black asked about the increase in gains on investments from 2004 to 2005. He also asked when the high risk pool was initiated.

Mr. Walker said that the pool was started January 2002.

Senator Cameron explained that part of the reason for the gain on investments is because recently a decision has been made to invest some of the funds in conservative investments in order to have the money available when it is needed and to be able to get some return on it at the same time. **Mr. Walker** agreed and said it is a combination of this and the fact that the markets have improved and that more money is available to invest as the plan grows.

In response to a question from **Representative Black, Mr. Walker** said that $68,000 is the gain on investment for the month of August, 2005, but he suggested having a representative from Buffington, Mohr and McNeal (the company who handles the investment) give a report to the Task Force because it fluctuates quite a bit. **Senator Cameron** noted that the monthly income for August is higher than the annual income and that interest income is also a factor.

In response to a question from **Representative Henbest, Mr. Walker** explained that the claims incurred for the month of August were close to $500,000. **Representative Henbest** said if that amount is similar each month, the claims account would be up to at least $4 million by the end of the year. **Mr. Walker** said it will probably be higher than that because takes a while to see claims. **Representative Henbest** asked if that means the claims have at least doubled from last year. **Mr. Walker** said his handout only compares to August, 2005, to August, 2004, so that is not necessarily true.

Senator Cameron asked when the Health Savings Account (HSA) plan the Legislature added to this pool last year will start. **Mr. Walker** said the HSA plan would begin in January with certain deductibles. The individual deductible on this plan is $3,000 and the family deductible is $6,000 with a $1 million lifetime maximum and a $6,000 pharmacy maximum.

Representative Block asked if the types of claims and the number of people that have these diseases is similar to the entire population. **Mr. Walker** said no, because this is a group of high risk individuals. In a normal population, there are not as many large claims.

Senator Cameron asked for clarification of the study that said the state should have about $19 million in reserves. **Mr. Walker** explained that the study was done in November of 2004 and was based on the current population in the plan at that time. He said that number may actually adjust over time due to enrollment increases as well as claims utilization increases. He noted that the number of individuals in the pool in November of 2004 is consistent with the number in the pool today. The study took into consideration a 10% growth factor. **Senator Cameron** said that means the pool has been operating in a potential deficit situation. He said there are still lines of authority to obtain credit should the plan exceed certain limits, but unless something really goes wrong, it does not appear that those will be needed. **Mr. Walker** agreed and said the study looked ahead three years, and we are at the end of that first year. He said it is a 95th percentile assurance rate that the state would not exceed the funds that are available if the reserves were at $19 million. They are currently at about $13 million.

Senator Cameron asked how the board sets rates. **Mr. Walker** explained that an actuary looks at average rates for similar plans for the five largest carriers in Idaho. That average is taken to the board and they look between 125% to 150% of that average to set the rates. He said there is some question about how that average is figured. Historically the board has used a straight line average. It has been suggested that they go to a weighted average because that is more representative of what rates actually are.

Senator Cameron said that Idaho has been commended at times for its high risk pool because

Idaho is one of the few high risk pools that have a funding source and seems to be operating in the black while other states are not. He said recently the federal government has tried to improve and augment high risk pools but it has not recognized Idaho as their style of high risk pool. He asked if this has changed. **Mr. Shad Priest**, Department of Insurance, said that there is another round of funding being made available for high risk pools. He noted that Idaho has made some changes in its laws that will hopefully allow Idaho access to some of those funds.

Representative Black asked if federal funding offsets some of the state money needed for such a plan. **Senator Cameron** said essentially yes, but since the actuary says we are behind where we need to be, he is not sure. There is a delicate balance between fiscal security today versus fiscal security tomorrow. Federal funding would help with that and would lower the need for rate increases. He thinks the rate increases recommended are less than standard market increases.

Senator Cameron explained that there are two ways to get into high risk pool: (1) be denied coverage from regular insurance or (2) the premium in the private sector is higher than participation in the high risk pool would be. As private carriers raise their rates on traditional products and the high risk pool rates do not increase at the same speed, it opens that door wider as to who can participate in the high risk pool. There is also still the opportunity for the carrier to cede the risk. **Mr. Walker** added that once someone selects a pool product, it is mandatory that the carrier cede it in. He said one challenge is if the pool does not keep pace with the private sector, it can be viewed as a competitor because more individuals will enter the pool because the product is less expensive, not because they are high risk individuals.

Senator Compton asked if the premiums are paid by individuals in the high risk pool. **Senator Cameron** said yes, but that carriers also pay to cede the risk. There is a premium set for individuals by the board for the different high risk products. Once someone has been denied regular coverage, insurance companies are required, by statute, to offer the high risk pool coverage. These high risk products have the same premium no matter what insurance company a person is with. In his opinion, this collaboration between private carriers and the state is one of the strengths of the program.

Representative Henbest asked what the range of premiums is. **Mr. Priest** said he would get that information before the end of the meeting and noted that it is also listed on the Department of Insurance web page.

Representative John Rusche, M.D., was introduced to discuss a Health Data Authority in Idaho. He explained that this was presented to the legislature as House Bill 148 last year. He said this proposal was brought forth because of the nature of the medical community and clinical community in Idaho. He said it is important to remember that the quality and cost of health care can be improved with improved analysis and greater transparency of what actually occurs. There currently is no way to aggregate and analyze healthcare data in our state.

Representative Rusche explained that health care makes up about 15% of all Idaho goods and services, making it larger than agriculture or any single manufacturing center. Health care also

continues to grow more rapidly than any other segment of the economy. He said with Idaho's low population, it is impossible to get adequate numbers of data points to make good analysis. The information from various carriers and payers needs to be aggregated so there are enough data points to see what is going on. **Representative Rusche** continued by explaining HB 148 and how a health data authority would work in Idaho. A full copy of his presentation is available at the Legislative Services Office.

Senator Cameron asked if the data collected would include, for example, information on how many heart surgeries are done. He also asked how this would help consumers with cost and quality of care. In his opinion, gathering such information would seem to be more useful at the governmental level if they were deciding whether or not to curtail or ration care. **Representative Rusche** said that a significant portion of health care costs for services are paid by the consumer. He said there is variation of cost and quality of care and that variation is currently hidden. A person can get the average Medicare cost for a service through Medstat, and there is another website available showing the number of services and the cost, if there are enough of those services, done at a hospital. Blue Cross and Regence BlueShield have their own claims history and they may pay providers different amounts depending on how they perform, but this is their own data set. He noted that most of these websites say that for most of the procedures done in Idaho, there are not enough data points to make meaningful reports on either the cost or quality of services. He believes that putting all of this data in one place would allow the consumer to be able to make informed decisions based on the type of care provided and the number of certain types of operations performed at certain health care facilities. In his opinion, if there is no health data authority, each of the carriers is going to develop its own measurements because products are becoming more consumer directed. If this happens, the data for each group may not match the other groups or there will not be enough data points to make statistically sound value decisions.

Senator Cameron noted that the assumption that hospitals or providers that do the most operations are providing the best quality of care is not always true. **Representative Rusche** said there is evidence showing that those who provide the most services usually provide the best quality of care, but even if that is not true, it is good to have information available.

Senator Cameron asked to what extent the cost of services provided in different areas would affect the decision-making process. He said that when his daughter was ill he did not care about looking to a health data authority for information, he just wanted care. **Representative Rusche** said that this is what normally happens, but developing a system to provide information for consumers who are being given more responsibility as to their health care is also important. When consumers need to make a choice, it is important to have the best information available.

Representative Henbest said that in her opinion the authority as proposed in HB 148 does not go far enough in terms of transparency. She said she would support such an authority if it did so and had clear reporting of quality outcomes at hospitals for certain procedures and if it included cost data. She added that consumers may or may not choose to use it. She also agrees that as the system requires consumers to be more responsible for care, information needs to be available in

order for them to be able to make informed decisions. She asked how HB 148 could be changed to increase transparency. **Representative Rusche** said that to improve the legislation, people who are involved in health care would need to decide what they can and want to submit as well as the stakeholders deciding what they want out of such a system. He added that there is value in having aggregated data on the health care system for purposes of direct analysis.

Senator Corder asked how aggregation of data would help small rural providers. **Representative Rusche** said that as a provider himself, having such information available would allow him to share information on costs and quality of care with families and it would help him make an informed decision as to where to send them for care. It would also help providers learn which services are oversupplied or under supplied. It would also help a provider know where in the system of care patient care can best be improved.

Senator Corder said he has concerns with allowing those who will be providing the data to decide which data to provide. In his opinion, there is a danger that this data might not be as transparent as the Legislature might like. He said that maybe the Legislature should tell them what data to provide in order to get the appropriate information to constituents to allow them to be able to choose providers as well as what services they receive. He asked if this is also part of the idea. **Representative Rusche** agreed that it is important for consumers to be able to make informed decisions as to where they get care and this will help them do that. With regard to the transparency issue, **Representative Rusche** said that the method of having the data submitters define and build the health plan was an attempt to try to get willing participation from providers. In his opinion, there is something in this for everyone, including the hospitals and providers.

Senator Compton said there is a need for better information to be available to allow people to make informed decisions. He said he would like to see information as to what other states are doing with such information and how this is helping them. **Representative Rusche** said he would provide a copy of the Utah plan update that includes hospital performance, safety, costs, patient safety, pharmacy claims database, pubic use datasets and a study of health savings accounts in the Utah market.

The next item on the agenda was a panel discussion on hospitals and their role in the future of health care. **Mr. Steve Millard,** Idaho Hospital Association, was introduced to give background information on the increase in spending for hospital care. He said that in Idaho there are 39 general and acute care hospitals, four federal and state hospitals. Of the 39 hospitals, 24 are either county-owned or a hospital district or governmental in nature; 12 of the 39 are private not-for-profit hospitals; and three are investor-owned, for profit, hospitals. Of all of those hospitals, 26 have a designation by Medicare called critical access hospital, meaning they are reimbursed on a cost basis rather than a prospective payment basis. The reason for this is because Congress recognized after many years of small hospitals closing, that low volume facilities do not work on a fixed payment basis.

Mr. Millard went on to discuss a study conducted by the Lewin Group and commissioned by the American Hospital Association titled The Cost of Caring: Sources of Growth in Spending for

Hospital Care. The presentation includes charts showing how advances in medicine are leading to longer and better lives but that rising health care costs are creating many concerns. He explained that spending on hospital care has lagged in growth compared to other health services, but hospitals still represent the largest component of total growth in health care spending. His presentation showed various components that are contributing to increased costs for hospitals. The complete presentation is available at the Legislative Services Office.

Mr. Millard concluded by stating that improving health care for society as a whole, while at the same time addressing issues of affordability, will require a greater understanding of the drivers of increased spending and better measures of what we are getting for out health care dollar.

Mr. Millard introduced the panel members: **Mr. Carl Hanson**, Administrator of Minidoka Memorial Hospital, **Ms. Janelle Reilly**, COO at St. Alphonsus Regional Medical Center, and **Mr. Ed Dahlberg**, CEO at St. Luke's Regional Medical Center.

Mr. Carl Hanson explained that Minidoka is a county-owned hospital and nursing home with $20 million in patient business per year. Forty percent of that is paid by Medicare. He noted the concern that more that one-third of the hospital business is for indigent or uninsured care and that the amount of charity care provided has increased 300% and is expected to continue to increase. Self-pay has increased about 15% in the last two years following trends in other health care markets.

Mr. Hanson said that he appreciates the Medicaid program, and that while it is criticized as a runaway expense, the problem is actually the growing number of people who are without health insurance that turn to it once they can qualify. Having said that, **Mr. Hanson** showed the Task Force a number of remittance documents from Medicaid to drive home a point Minidoka Hospital struggles with. He explained a bill for an outpatient surgery that resulted in the patient having to stay in the hospital for a couple days: The patient incurred a bill of $17,283 and the hospital was paid $958.00 by Medicaid. He noted that the payment does not even cover the cost of supplies, and this makes it very difficult to run a business. **Mr. Hanson's** presentation also included a letter the hospital receives from Medicaid each year stating the hospital's interim rates. He said that the rate given in the letter is actually much higher than what they actually get in reimbursement and that claims are about 4 years behind.

Mr. Hanson continued by stating that the commercial market is trying, through contract addendums or new contracts, to pay the discount negotiated with the hospital from charges or from the carriers fee schedules. In other words, a hospital could be negotiating a discount of 3% to 5% on a fee schedule that is already 30% to 40% below the hospital charges. It is increasingly difficult to transfer the cost of caring for the indigent and uninsured to the commercial market.

Mr. Hanson said the key message regarding non-profit hospitals is to expect more consolidation. These discussion are taking place in Idaho. One of the driving forces behind that is to preserve the ability to cost shift by dealing with payer groups that are nationwide and very large. He noted that at a conference he attended Blue Cross was criticized for it pre-authorization

requirements for radiological studies. Their response was that these requirements had been developed due to the unexpected increase in utilization per patient in physician-owned imaging centers. When he returned home, he looked at a comparison of this in his area and found that the physician-owned center was averaging 14 MRIs per week, which is 300% higher than at Minidoka Hospital. He encouraged the Task Force to look at whether this type of self-referral is contributing to higher health care costs. He said he asked Blue Cross about this and they did not have an answer.

Ms. Janelle Reilly explained that St. Alphonsus is a community hospital with about 380 beds and about $500 million in gross revenue. It is a not-for-profit organization and a member of the Trinity Health Organization. The hospital is known for trauma care, Life Flight, neurosurgery, orthopaedics and surgical services, and owns the largest primary care network in the Treasure Valley. She noted that the hospital received numerous awards for quality care from HealthGrades, including the Top 100 Hospital (neck and back, cardiac and ortho) and Top 100 Most Wired. In 2005, the hospital contributed about $40 million in community benefits. Slightly less than one-half of that goes to charity care and more than one-half goes to pay the unpaid costs of Medicare and Medicaid.

Ms. Reilly stated that her one message for the Task Force and other health care providers would be to focus on some challenges that health care faces in trying to contain costs and focus on what can be done together. These challenges include the uninsured, the nursing shortage that is looming, telemedicine and electronic records (both personal and medical) and mental health and substance abuse. Before discussing these challenges, **Ms. Reilly** said that hospitals have been engaged in initiatives to contain costs and improve the health of Idahoans. She noted that while the costs of goods and services hospitals purchase can add billions to the cost of hospital care, they also result in improved outcomes, longer life expectancy and a better quality of life.

Ms. Reilly said St. Alphonsus is working hard to buy these goods at aggressively negotiated prices. She noted that this is more difficult than it seems because physicians are mostly independent contractors but are responsible for ordering care in the facilities and therefore control about 80% of their costs. In an effort to keep spending down, managers on every shift are managing productivity to national benchmarks and investing in technology and automation to streamline the workload for caregivers and make the staff more efficient.

Higher demand also results in increased costs. **Ms. Reilly** said that as the population grows and ages each person, on average, will use more hospital services. Facilities are being replaced to meet these needs. It is estimated that by 2010, the Treasure Valley will need 1,095 beds; a shortfall of 200 beds.

Ms. Reilly stated that information technology has been identified as an essential tool in improving the quality of clinical care and reducing health care costs. St. Alphonsus is investing $24 million over the next ten years to address quality and patient safety initiatives such as electronic medical records, clinical documentation, computerized physician order entry and automation of medication administration. This will help reduce redundancy in the system. She

noted that these good works emphasize that everyone is working hard to contain health care costs, but in her opinion greater results would be produced by joining forces.

Ms. Reilly then discussed the following issues that, in her opinion, can be addressed by working together.

The uninsured

- In 2003, 18.6% of Idahoans or 1 out of 5 are uninsured; approximately 20% of these are children. Idaho's uninsured rate more than doubled the national average: 5.2% versus 2.4% between 2002 and 2003. The uninsured experience worse health and die sooner. The uninsured use expensive emergency departments because they have no medical home and therefore no continuity of care. Hospitals must recoup the costs of treating the uninsured through charges to paying patients. Eight out of ten uninsured adults are working or members of working families. This is largely an issue of eroding employer-sponsored coverage. There is a growing problem of under-insurance.
- Possible solutions to the uninsured problem include: strengthening the Access Card to enroll more people; consider tax credits to small businesses to encourage them to offer health insurance; consider developing a pool, such as an expansion of the state employee pool, for individuals and small businesses to buy into; and strengthen Medicaid and CHIP to enroll more eligible people and to reimburse providers adequately so that Medicaid coverage ensures access to providers.

Nursing Shortage

- The nursing workforce is aging: 28% of employed nurses are age 50 or older, 56% are age 40 or over. By 2008, the State Board of Education projects Idaho will need 30% more registered nurses. The Federal Department of Health and Human Services estimates that Idaho's nursing shortage by 2020 will be almost twice the national shortage if current trends continue. In 2004, Idaho universities turned away over 1,000 eligible nursing applicants because they did not have the capacity in their nursing programs; part of the issue is a lack of competitive salaries.
- Possible solutions to the nursing shortage problem include: Redesign the systems and processes in our hospitals to be more efficient for the nurse care. Fund more faculty positions and offer competitive wages to train more nurses.

Telemedicine/Electronic Medical Records (EMR)

- The combination of adult baby boomers and the internet is creating informed, empowered consumers. Informed consumers can be powerful in reducing costs. It is important to have the right information to the right provider at the right time in that it reduces redundancy of tests and allows care to be delivered in a timely fashion saving lives and dollars. An EMR initiative is underway in Idaho to share clinical data electronically among providers.
- Additional solutions would include investing more in the electronic infrastructure on a statewide basis to allow more access, adopting virtual integration standards,

and investing more in deploying more telemedicine equipment and devices to all parts of Idaho.

Mental Health

- Suicide is amount the top ten causes of death in Ada and Canyon Counties. Idaho youth suicide rates are more than double the national average. Firearms are the leading method of suicide in Idaho, then poisoning. Access to treatment providers is a problem, especially due to cost issues. Capacity in Idaho's facilities is also a problem, causing waiting lists or utilization of the ED. There is frequently a two to three month wait for those who need state hospitalization, so they are often warehoused in acute hospitals, which exacerbates the limited bed availability. Lack of capacity in behavioral health services results in unmet acute needs, which often become chronic needs in terms of severity and persistence of illness. Every Idaho county is a health professional shortage area (HPSA) for psych providers.
- Possible solutions include: Continue to support the mental health subcommittee. Provide more psych beds (the State hospitals are shrinking and closing and the private facilities are running at capacity). Develop outpatient early intervention venues. Provide medical assistance for mental health patients who are unable to afford them. Find ways to attract more psych professionals or find a way to share our scarce resource throughout Idaho maybe via telemedicine.

Substance Abuse

- Teenage substance abuse rates in Idaho are higher than the national average. Law enforcement reports that at least 3/4 of prisoners are in jail due to substance abuse related issues. The Idaho Kids Count assessment indicates concern about the numbers of students who have been offered, sold or given illegal drugs on school property.
- Possible solutions include: Provide support for the Ada County detox facility. Support expansion of substance abuse services throughout the state.

Ms. Reilly concluded by stating that Idaho hospitals would like to be an active partner in shaping various health reform initiatives, both on the delivery side and the health financing side.

Mr. Ed Dahlberg was the next panel member to speak. He said the everyone needs to remember that the health care system was not invented - it *evolved* in a way that created some differentiation in approach or interests that contributes to the difficulty in finding a solution. He said that as strongly as he advocates for the hospitals, he appreciates that a solution will not be reached unless all of the parties find a way to come together. The parties that need to be involved include the government, both state and federal, patients, insurers, physicians and hospitals. **Mr. Dahlberg** said that the current health care system is unsustainable and a solution must be found.

Mr. Dahlberg noted that the current system, particularly from a government perspective, is designed around age or income. He said that just because a person turns 65, that does not mean they need coverage for primary care or that someone under 65 years of age needs assistance from

catastrophic diseases. How is it that we target our coverage systems on age rather than disease? According to **Mr. Dahlberg**, changing this thinking would allow the system to be more efficient. He said he could make the same argument about Medicaid and economic status. He said he is not suggesting that not everyone needs access to preventative care as well as catastrophic coverage, but maybe there is a way to rethink the way we look at these problems on a higher level.

Mr. Dahlberg said that once a health care service is provided, it is the utilization that impacts health care premiums much more price. When a provider does twice as much of something, it raises the cost a lot more than a 10% increase in an insurance premium. We tend to focus on price and in his opinion, there has to be a way of addressing utilization and whether or not the procedure was necessary, appropriate and in the right setting and place. **Mr. Dahlberg** said that one frustration in hospital management is how much control they really have. Physicians admit patients and order tests; the hospitals make them available. **Mr. Dahlberg** summarized a study done by Blue Cross regarding what impacts health care costs as follows:

- 19% technology
- 12% pharmacy
- 20% workforce/demographics
- 15% loss of available resources to limited service hospitals
- Government under-reimbursement/cost shifting (36.9 cents on the dollar)
- Regulation: what they will pay for, how to do it, when to do it
- Defensive medicine
- IT integration

Mr. Dahlberg stated that community hospitals are the community safety net and give the uninsured a place to go for care. There are costs incurred to keep services available because hospitals are open 24 hours a day, 7 days a week.

Senator Cameron asked for more information on the reimbursement rate from Medicaid. He said it was his understanding 26 of Idaho's 39 hospitals are critical access care hospitals, which provides an additional reimbursement level from the federal government. He asked if the state takes into account whether or not the hospital is a critical access hospital in determining its reimbursement level.

Mr. Hanson explained that critical access hospitals get 96.5% of allowable costs from Medicaid, compared to 81% for non-critical access hospitals. Medicare currently pays critical access hospitals 101% of allowable costs. **Senator Cameron** asked if the allowable cost for both Medicaid and Medicare are figured the same way. He said it was his assumption that these allowable costs would be significantly lower than that of the private sector. **Mr. Hanson** said that was correct, and that the allowable costs originate in the Medicare cost report and both Medicare and Medicaid use that report to determine what the allowable cost would be.

Senator Cameron said it was indicated to him that a family policy is impacted by $1,400 per year based on unreimbursed care. So, in essence, there is a cost shift to the insured public from the federal and state government not paying the actual cost for treatment of these patients.

Senator Compton asked about the cost of paperwork and billing. **Mr. Dahlberg** said the cost of paperwork is one of the main reasons there is so much emphasis on information technology. In a study done with other hospitals about 2 years ago, it was shown that every hour a patient spends in the ER generates one hour of paperwork; one hour of surgery generates 45 minutes of paperwork.

Senator Compton said that an article he read showed that the U.S. spends about one-third to one-half more for health care than other countries. He asked whether this was true and, if so, why we are paying so much more for care but not living that much longer. **Mr. Dahlberg** said such statistics depend on what kind of care is expected, what is measured and what is provided. This is very debatable. In Canada, 5% of those needing hip replacements get them in 30 days; in the U.S. that number is 71%. Americans have higher expectations.

Representative Henbest asked about the self-referral issue and how federal law plays into this. She asked if there is any place for states to regulate the issue. She also asked, regarding the Health Data Authority, how eager the hospitals would be to come to the table and give information regarding what their charges are for the uninsured, Medicaid, Medicare, Blue Cross, Blue Shield and so on, as well as quality data.

Mr. Dahlberg began with the self-referral question. He said that federal legislation known as the Stark Bills prohibited physicians from owning certain types of health care facilities to which they can refer patients. The legislation allowed the owning of whole hospitals. Since that time, the definition of a hospital has changed and a large loophole has been created. The response to that nationally was for Congress to impose a moratorium on free standing hospitals for 18 months. This expired in June, but the entity that defines payment for these types of facilities has continued that prohibition against paying for any new facilities until further study is done. There is currently a bill in Congress to prohibit self-referral or a physician owning anything to which he can refer patients because of documented studies on utilization rates being impacted.

Regarding the Health Data Authority question, **Mr. Dahlberg** said that public reporting is very important. What is reported and the accuracy of what is reported is critical. What is it that is important to know and how current is it? In current reporting systems, most of the data is two years old and it is Medicare data only. If reporting is going to be required, the information has to be reliable. **Mr. Dahlberg** said that all of the hospitals are participating with a CMS joint commission on the public reporting of some outcomes data, chronic heart failure, community acquired pneumonia and surgical infection rates. As to the reporting of contractual payments and costs, he has more of a problem with that in the sense that since this is a competitive market, there needs to be a way to fairly disclose costs. **Mr. Hanson** and **Ms. Reilly** agreed that this is important but that the reporting has to be standardized. The data collected needs to be in a centralized location, especially as consumers become more responsible for health care choices.

Senator Stegner said since he has become a legislator, he has developed the opinion that there are several important issues facing the state. These include substance abuse and health care costs. He said he agrees with the earlier statement that the health care system is unsustainable as it

exists today. He noted that the Legislature spends more time figuring out what to do with the rising cost of health care than anything else. He commented one of the problems seems to be that hospitals and the medical community are presenting the image that they are unconcerned about increasing costs and continue to pass on those costs and expand their system, expecting society and/or the government to handle the costs. He said he realizes it is not quite this simple, but some of the actions of the medical community, such as advertising campaigns that seem to be a waste of money, could be used elsewhere to actually help reduce health care costs.

Mr. Dahlberg commented that in the current system everyone is expected to protect their own interests. He pointed out that it was the government that decided to make the market competitive. He said that advertising is a small portion of the budget that provides more angst that anything, but it is the result of competition and perhaps should be revisited.

Mr. Hanson said that Minidoka has been losing residents by about 5% a year since Simplot closed its Heyburn plant in 2001. He commented that what is happening in the Treasure Valley is not necessarily what is being experienced statewide. He noted that if advertising did not work, hospitals would not do it and added that advertising budgets for small community hospitals are very small. He said most of Minidoka's advertising is service-oriented, such as providing bicycle helmets for children in the community.

Ms. Reilly agreed and said that there needs to be some type of forum created to allow everyone to work on solutions. In her opinion, the creation of a statewide data base is a good foundation for making planning decisions. She said one thing the Task Force needs to understand about health care facilities is that most of these facilities are very old and were built with government funds that no longer exist. Facilities have to be replaced, and she said they are trying to be mindful about building in an efficient manner and only what is necessary.

The next agenda item was a presentation on the Government Employees Medical Plan (Gem Plan). **Senator Cameron** explained that there will be three panels, one including people from the Gem Plan, another includes other insurance carriers, and another with representatives from the Department of Insurance. He introduced **Jim Guthrie,** Bannock County Commissioner, **Seth Beal,** Butte County Commissioner, **Duane Smith,** Minidoka County Commissioner, and **Todd Lakey**, Board Counsel for the Gem Plan, to begin the discussion.

Mr. Lakey distributed a Gem Plan handbook, a copy of which is available at the Legislative Services Office. **Mr. Guthrie** explained that the Gem Plan is a multi-county, multi-funded health care plan allowed through the joint powers agreement and Title 41, Section 40, Idaho Code. **Mr. Guthrie** said that as a county commissioner, after being involved in the county budgeting process, he appreciates the 3% cap that was instituted. Having said that, though, he said that annual increases in health care costs exceed that 3% cap so they are forced to look for health care coverage options. He explained that the Gem Plan board consists of one individual from each of the state's six districts and one member at large. The six district representatives are selected by elections held at a district meeting, and the member at large is selected by a statewide vote. The board has adopted bylaws and has contracted with a company (Mutual Insurance

Agency) that acts as the general manager and employs an executive director. The general manager handles the day-to-day operations of the plan and the duties that an insurance agent would typically handle. **Mr. Guthrie** said that if a county is more comfortable working with an agent of their choice, they can to that. The executive director works on a part-time basis. He said CBSA is the plan's third party administrator that handles the third party administrative needs; reinsurance is provided through ING.

Mr. Guthrie explained that there are currently 21 counties participating in the Gem Plan, with about 1,900 employees and 2,400 dependent lives being covered. As a start-up situation, they have a desire to build a solid and viable program. He summarized the following challenges the plan is facing.

- Developing provider networks and getting the appropriate discounts.
- Helping employees understand the importance of utilization and recognizing that health care is a resource that is getting more challenging to fund.
- Legislation regarding regulation.

Mr. Guthrie noted that as a result of proposed legislation, the Association of Counties has passed a resolution that says there are more than one-half of the counties in Idaho that are either in a single self-funded plan or a multiple county self-funded health care plan and that if legislation is so adverse to that philosophy or approach that it kills these types of plans, it would be detrimental to Idaho counties and the Association of Counties would not support such legislation.

In response to a question from **Representative Deal** asking for a review of the booklet the group presented to the Task Force, **Mr. Lakey** went over the table of contents. He explained that tab 1 includes an overview of the Gem Plan and background information He said that this plan has been in discussion for a couple of years with the Department of Insurance. Tab 2 contains a copy of the joint powers agreement that sets forth the relationship of the various counties that participate in the program and how the organization is structured and managed. It also establishes the dispute resolution process. This is basically the governing document for the organization. Tab 3 contains a summary plan document, select benefits and a sample schedule of benefits. Tab 4 includes resumes of the program's actuary and an underwriter and consultant who works with the plan. Tab 5 includes a draft proposed legislation from the Department of Insurance. Tab 6 is the Attorney General's opinion that Representative Black requested last year regarding the plan.

Representative Deal said that he was hoping the presentation would include a financial statement of the fund and asked if that was available. **Mr. Lakey** said they would be happy to go over that information with the Task Force at a later date.

Senator Cameron said that as legislators it is their job to find ways to curtail costs, but it is also their duty to protect consumers and to make sure there is a level playing field for all insurance carriers that are providing coverage. He said that a bill that was presented last year attempted to bring the Gem Plan under the regulation of the Department of Insurance. He explained that there

are different levels of regulation based on the type of plan and that currently the Gem Plan has no regulation that fits under the Department of Insurance. This means there is no place for an employee of a county to turn to if they have a claims dispute. He added that there is a considerable difference between a county that is self-funded on their own and assuming the risk and how they are regulated by the Department versus a multiple county arrangement.

Senator Cameron asked if they are opposed, as a board, to being regulated in a similar manner to other plans operating in Idaho. This would include providing financial information and allowing the Department to be able to respond to consumer complaints. **Mr. Guthrie** explained that the plan was started under existing laws in Idaho and they would not be opposed to regulations as long as they were allowed to transition into a more regulated environment.

Mr. Lakey said that best case scenario for the Gem Plan would be to operate under existing laws. He agreed with **Mr. Guthrie** that some type of agreement can be reached regarding regulatory legislation. Their concern would be that the legislation would not recognize the unique character of the Gem Plan being comprised of governmental entities and the differences that exist with governmental entities. It is his understanding that there are varying degrees of legislation dealing with government self-funded plans across the country and suggested those be looked at.

Senator Cameron explained that being a governmental entity does provide some unique benefits and potential detriments. If a plan were to go insolvent, that falls upon the property tax payers of those counties. He said he wanted to draw a distinction between a county that is self-funded on its own that has chosen to take on the risk of their own employees within their own county and a multiple employer arrangement such as this plan that requires counties to take on the risk of all counties in the plan. He said the first issue he has regard the appropriate role of regulation. He said this is a discussion that the Task Force, the Department of Insurance and those involved in the Gem Plan need to have. He went on to express concern that those present today to speak about the plan are not the financial, actuarial individuals involved. A repeated concern that he has heard has been public comments made by those with the fiscal information about the plan and the lack of information being shared with county commissioners, including the ability for an employee or spouse to be carved out under a multiple employer arrangement. He explained that "carved out" is an insurance term meaning the reinsurance carrier can decide they are no longer going to reinsure that person; this happens with self-funded plans. **Senator Cameron** said he has heard that this has happened twice with the Gem Plan.

Senator Cameron continued by stating that there have been reports that representatives of the plan have indicated that there is no additional risk to the county or the county employees by choosing this type of plan. He said that is inaccurate and it is unfortunate that this type of comment would be made. He stated that during the Senate hearings last session, **Mr. Ramirez** from the Gem Plan was asked several questions that he could not answer dealing with reinsurance levels, stop loss levels for which reinsurance would kick in, and aggregate and individual stop loss levels.

Mr. Guthrie stated that the plan has not carved anyone out beyond what would be appropriate. He said there was one individual who no longer met the requirements for coverage because he no longer worked for the county. He stated that there were two individuals lasered in the first year of the plan so the reinsurance kicked in at $125,000 and $150,000, instead of the typical $75,000. He said in neither case did those stop loss limits exceed $75,000 and it ended up being a nonfactor in 2004. In 2005, there were five individuals lasered by the reinsurance carrier. He said they are currently bidding the stop loss package to include quotes that will speak to a nonlasered quote and a lasered quote in order to be able to get a feel for what the reinsurer sees in terms of risk. He said it is difficult to get quotes from the reinsurer without the lasering component being included unless there is more than a couple of years of history.

Senator Cameron asked whether **Mr. Guthrie**, when the decision was made to go to this pan, felt adequately informed and felt employees were also informed of the fact that employees, spouses or children could be lasered or carved out, or whether it was portrayed that there was no additional risk. **Mr. Guthrie** said Bannock County was somewhat self-insured before they entered the Gem Plan and it was somewhat typical to have an employee or two lasered.

Senator Cameron asked since the specific stop loss is $75,000, if any claim higher than that goes to the reinsurance carrier which is ING and what is the aggregate stop loss. **Mr. Guthrie** said it is $1 million. **Senator Cameron** said that means that if the counties collectively had $1 million worth of claims of any size, anything above that million would go to ING. **Mr. Guthrie** said he does not fully understand the aggregate reinsurance component. It is his understanding that once the claims reach 125%, then there is $1 million and then it could kick back. He said the bigger the pool gets, the lower the probability of that happening. **Senator Cameron** noted that the amount is a high aggregate stop loss so it may not be correct.

Mr. Lakey clarified that the stop loss carrier does the lasering of specific employees. He explained that the plan itself has not lasered an employee and they remain covered under the plan. He admitted that this does provide some additional risk to the plan. **Senator Cameron** said that was the way he understood it and clarified that once the stop loss carrier lasers someone, meaning they no longer provide reinsurance for that person, the employer is still obligated to provide coverage for them, but instead of being protected on any claim above $75,000, the employer is either completely unprotected or at a reduced protection level.

Senator Compton asked for an estimate of how much the plan is saving the taxpayers of counties that are in the plan. **Mr. Guthrie** said the intent of the plan is to create a stable environment, but that does not necessarily mean the rates will be significantly lower than other plans. The rates counties received were somewhat favorable when the came into the plan. He noted that the board has implemented a 15% increase that took effect on October 1,2005.

Senator Compton stated that the high risk pool hired a third party to look at whether their reserves were adequate. He asked if the Gem Plan has done this to get an estimate of what the reserves should be based on their exposure and losses in order to be able to cover claims. **Mr. Guthrie** said in the beginning they worked with actuaries to help build their business plan. He

noted that this needs to be updated and the board has been given direction to do this.

Senator Cameron asked if the 15% increase will be the only increase between now and next October. **Mr. Guthrie** said it is the board's intent that it will be the only increase for the year.

Senator Cameron said the Task Force would appreciate the financial data and suggested that the Gem Plan needs to have an actuarial study done for the benefit of all involved.

Mr. Gary Smith, Director of the Department of Insurance, was the next speaker. He commented that the Department considers the Gem Plan to be a Multiple Employer Welfare Arrangement (MEWA). He explained that MEWAs are established for the purpose of providing benefits to the employees of two or more employers. MEWAs can either be insured or self-insured. Self-funded plans generally cover part of the risk through a stop loss insurance. If the MEWA is fully insured, they purchase an insurance policy that treats them as a single entity and in that case, the Department regulates the insurer, giving them access to all of the information discussed today on soundness and safety. If a MEWA chooses to self fund, they act as the health insurer to employees by paying the health benefits from amounts collected from employees along with employer contributions. Under this option, which is the option the Gem Plan has chosen, they are subject to federal reporting requirements that the state is not able to regulate. **Mr. Smith** said that Chapter 40, Title 41 of the Idaho Code was amended in 2001 to include any plan administered by or for any county of the state. The Department interprets that to be any county. At the time of the amendment, there was no discussion about multiple county plans.

Mr. Smith noted that because MEWAs compete with and are generally marketed in the same way as insurance plans, a single failure of a plan can impact many employers and hundreds of families. He said the Department feels that all health plans in Idaho should be on a level playing field and should be regulated by the Department. Idaho is not immune from failures. There was a plan in northern Idaho that the Department only became aware of when employees contacted them for assistance collecting their claims. The ultimate outcome was a loss of over $300,000 in Idaho alone. He said that while consumer choice and competition in the market is very important, in this case the overriding concern is safety and soundness.

Mr. Smith continued by explaining that to comply with Chapter 40, a self-funded plan would have to comply with requirements including being registered with the Department. All contributions would have to be paid in advance and deposited and held in a trust fund under an agreement that is reviewed by the Department. The trustees would be required to provide a written statement of benefits to all members of the plan and it would be determined by the Department whether they were actuarially sound. He said that is the most important concern.

Mr. Smith said one reason the Department is concerned with MEWAs in general is because there is no guaranty association. All registered insurance companies pay dues into a guaranty association that is there as a backstop on which to fall back if necessary. The Department feels that since this does not exist for MEWAs, liability exists and in the case of counties, if the plan fails, the only way to pay claims would be to raise property taxes. He noted that MEWAs are

marketed as being the equivalent of insurance and they compete directly with legitimate insurers in recruiting employers and aggressively marketing with unrealistically low premiums to begin with. He said this is a general statement with regard to MEWAs but noted that the Gem Plan, within one year, has already raised rates. Due to these practices, it is relatively easy to attract employers into the plan.

Mr. Smith said that the Department has had cordial meetings with the Gem Plan people but they are under no obligation to register with the Department or to provide any financial information. If anyone wanted to know how they are doing, the Department could not help. Due to that fact, it is the opinion of the Department that MEWAs are not in the best interest of Idaho consumers and the Department has proposed legislation in this respect. He said there has been mention of joint power agreements, but the Department takes a different position on that and feels that there is some ambiguity in the law and by drafting this legislation, they want to clearly state that MEWAs need to be registered and monitored by the Department. **Mr. Smith** stated that the county employees pay their premiums, assuming benefits are paid in timely manner from a secure vendor. If that plan fails, besides losing coverage and all of the premiums they have paid in, they are also going to be sued by the hospitals and doctors for costs.

Senator Corder clarified that the proposed legislation does not seek to eliminate MEWAs; it just seeks to have them register with the Department and allow the Department to monitor MEWAs for soundness. **Mr. Smith** said that was correct. The legislation states that MEWAs must register just like any other company providing health benefits in Idaho and would be subject to the same reporting requirements. He noted that the legislation does include a grandfather period to allow them time to comply.

In response to a question from **Senator Compton, Mr. Smith** explained that the legislation includes a requirement that MEWAs establish a trust account and deposit premiums into that account, which would be monitored by the Department. He clarified that regarding state health care, the Department regulates the insurer but the state is not the insurance company. The Gem Plan, on the other hand, is the actual insurer for counties. **Senator Compton** said he thought that in regard to the state health care plan, in the past the state took some responsibility for some of the claims. **Mr. Shad Priest** said the former state plan was like a self-insured plan, but Blue Shield was ultimately responsible for claims and had an account for those claims.

Representative Henbest asked if MEWAs were regulated by the federal government if they are not under state regulation. **Mr. Smith** explained that under ERISA, private plans that are a single employer are not covered by state regulation. There are slightly different rules for governmental entities. **Mr. Priest** explained that a governmental self-funded plan is not regulated at the federal level. Multiple employer plans for private employers are regulated at both the federal and state level. He said that for governmental multiple employer plans, it is up to the state to decide if there will be any regulation other than certain HIPAA requirements.

Representative Henbest commented that insurance companies coming in with low premiums and raising prices is not an uncommon practice in general and she thinks competition is good.

She asked where the problem is for this. **Mr. Smith** said the difference would be that regulated companies submits rates to the Department for review and approval. In a situation such as the Gem Plan, the Department does not know the basis as to why the rates were set at that level. **Representative Henbest** said she is still struggling with how rates are set to begin with and what role the Department. She said she would like more information on that in future.

Senator Cameron said that some companies offer low rates to get business and then move on. He said that there is a general tendency of MEWAs to do this nationally and they are not accusing the Gem Plan of doing this. **Mr. Smith** said that was correct.

Senator Kelly asked why single employer self-funded programs are not regulated. **Mr. Smith** said that the ERISA federal law exempted single private employer plans to try to allow them to be more competitive. **Senator Cameron** added that part of this is based on who is taking the risk and whose risk is being assumed. Under a single employer self-funded plan, the employer purchases insurance based on data gathered about its own employees. This is done at the risk of the employer. **Senator Cameron** continued that under a multiple employer arrangement, it is more complicated because if one goes bankrupt, other employers are responsible for this and could lose coverage. Multiple county arrangements are even more complicated.

Mr. Priest said another problem with MEWAs is that in essence they are acting as the insurance company. There is usually a third party taking in money on behalf of many employers and managing that money and paying claims. This creates a huge opportunity for fraud. He said that a 2000-2002 study showed that Americans lost $252 million in unpaid medical bills because of fraudulent or mismanaged multiple employer arrangements. Single employer plans do not have the same problems because they do not grow beyond the employee base.

Senator Compton drew a distinction in the case of the Gem Plan because the people in charge are elected officials in their counties and are very visible to their citizens. **Mr. Smith** agreed and reiterated that the comments made are not against the Gem Plan; they are just about MEWAs in general. The current Gem Plan operation is considered to be a MEWA and the Department feels an obligation to point out the problems. He said the Department wants to help the Gem Plan to be successful by giving them a grandfather period.

Julie Taylor, Blue Cross of Idaho; **Elwood Kleaver**, Primary Health; **Woody Richards**, Property Casualty Insurers Association; and **Scott Leavitt**, National Association of Health Underwriters, were the next panel introduced to discuss the Gem Plan.

Mr. Richards said that the group he represents is made up of 1,000 property and casualty insurance companies. He pointed out that none of these companies compete with the Gem Plan but they do have an interest in the issue for the following three reasons.

- They subscribe to the idea that there needs to be a level playing field. Everyone should play by the same rules if they are selling the same product.
- They believe the lack of regulation is unfair to consumers. Consumers under any

circumstances still need an advocate for purposes of protection.

- If plans such as the Gem Plan or other MEWAs experience difficulties, these difficulties will only feed the calls for preemption of state taxation and regulation that affects the entire insurance industry.

Mr. Richards explained that the existence of the Gem Plan is somewhat of a fluke. The sponsors of the 2001 legislation (Kootenai County, Ada County and Canyon County - all individual plan counties) were concerned with having better control over their investment funds. No one was made aware at that time that there were any plans for the creation of a Gem Plan. The wording of the statute said "county" singular, and as a consequence the Property Casualty Insurer's Association did not oppose the legislation. He said that only subsequently representatives of the Gem Plan argued to the Department that what is authorized for one county is legal for all counties under a joint powers agreement. He distinguished this from other parts of the insurance code in that any time the Legislature intended to have more than one group of entities involved, it specifically allowed the joint powers agreement to be used. **Mr. Richards** noted that it is a matter of first impression for the Legislature as to what it wants to do with an entity such as the Gem Plan. There should not be any type of assumption that the Legislature has already reviewed it and made a knowing decision that there should be an unregulated entity in existence.

With regard to potential savings, **Mr. Richards** noted that nothing is unique about the Gem Plan with regard to health care costs. It will not cause medical bills to decrease nor will it reduce utilization of medicine. It will not decrease the cost of new equipment or drugs and it will not keep our population from aging any differently than any other entity. **Mr. Richards** said others in the insurance industry understand the motivation of the Gem Plan to want cheaper health care protection, but they strongly disagree with the means being utilized. He noted that there is the potential that the Gem Plan will save money because they do not have to pay the expense of regulation. The Gem Plan does not have to pay premium taxes or regulatory fees, nor submit to regulation to provide customer protections. It does not have required audits or actuaries, although some of this may be done voluntarily. He said that if the intent of the Legislature is to say that the way to save money is to remove regulation, it ought to be removed for everyone.

Mr. Richards said the organizations he represents would probably not support voluntary compliance because the term "voluntary" means an entity can change its mind at any time. That is the same reason all insurance companies are not given the option of voluntary compliance. He added that the county commissioners that sit on the Gem Plan Board are not full-time members of that board. They are full-time county commissioners that have many other issues demanding their attention. **Mr. Richards** stated that while this plan might have excellent intentions, the next plan that uses this exemption might not It is the idea of setting a precedent and the opportunity for other people to create other plans once an exemption is created.

Mr. Richards said that he has some concerns over the use of stop loss as a cure-all for all types of problems. Most reinsurance arrangements are cancellable with relatively short notice. If a plan is required to replace its stop loss coverage, it can dramatically change the cost analysis and

there can be issues regarding how to handle incurred but not reported claims. Also, if a plan is questionable financially, it may have significant trouble finding a replacement carrier and the plan will be liable for any losses during that gap. Many people do not understand that there is generally no contractual obligation between the stop loss carrier and the plan members themselves. The stop loss carrier is obligated only to cover claims actually paid by the plan. It has no duty to the plan participants. If the plan lacks funds to pay claims, the reinsurer keeps the premium and is off the hook for claims since the self-funded plan did not incur a loss because it lacked the funds to pay the claims. The bottom line, according to **Mr. Richards**, is that if stop loss insurance is the cure all, the rest of the insurance industry would ask for a level playing field so that any insurer that has stop loss or reinsurance should have the same benefit of deregulation.

Mr. Richards agreed that carving out or lasering is also a concern. He noted that the Task Force needs to take into account that there are other governmental and quasi-governmental insurers in Idaho that have similar characteristics to the Gem Plan and that are regulated. **Mr. Richards** said he is somewhat encouraged by what was said earlier today that the Gem Plan and counties are considering coming under regulation and that they are concerned with having time to meet the regulatory requirements. He said it is not his intent to say they should not be given an opportunity to make the transition but he thinks it is entirely appropriate and fair to make them submit to the same regulatory requirements. **Mr. Richards** concluded by stating that if there are provisions of the law that should not apply because they are either too expensive or unnecessary, the insurance industry will be there to support efforts to remove those.

Ms. Julie Taylor was the next speaker. She explained that Blue Cross has been very involved with this issue since the beginning because of concerns about the unregulated health plan known as the Gem Plan. For the last two years, Blue Cross has been involved with legislation to create a level playing field. In an effort to analyze the situation, Blue Cross looked at a fraction of the regulations they are subject to and compared that to regulations for single self-funded plans and non-regulated self funded plans (Gem Plan). She distributed a chart, reproduced below and available at the Legislative Services Office, showing the different areas of regulation, including consumer protection, access to care and financial solvency. She explained that regulated plans such as Blue Cross are subject to all of the regulations, regulated self-funded plans are subject to most of the regulations, and non-regulated self-funded plans such as the Gem Plan are not subject to any of these regulations. A small example of the chart is below.

Idaho Regulation	**Regulated Plans**	**Non-Regulated Self-Funded Plans (Gem Plan)**	**Regulated Self-Funded Plans**
Consumer Protections:			
State regulates rates: how much can be charged and how often rates can be changed	YES, for individual and small group policies only	NO	NO, not applicable to self-funded entities but rates must be actuarially sound

State handles complaints from consumers and providers	YES	NO	YES
Access to Care:			
Company must include mandated benefits on policies e.g. mammography, cleft palate	YES	NO	Only mammography screening and coverage from birth
Financial Solvency:			
Required to maintain financial surpluses that grow w/ size of company	YES	NO	NO, but reserves must be actuarially adequate per certification by American Academy of Actuaries
Other Regulations:			
Company pays Idaho state premium tax	YES	NO	NO $.04/month/beneficiary tax instead

Mr. Scott Leavitt distributed a handout listing his organization's concerns regarding the Gem Plan. This handout is available at the Legislative Services Office. He said that on the surface, with the concern over rising health care costs, a plan such as this sounds like a great idea. The reality is much different. One concern is potential solvency issues. He explained that these plans have a contract with their reinsurance provider and if the plan becomes high risk or has a high loss ratio, these reinsurance providers can decide not to renew the contract. This means there is a potential that a plan might not be able to find another reinsurance company and that could open floodgates of unpaid claims.

Mr. Leavitt said that since this is multiple county plan, as rates go up at the end of the year, a county has the option to leave the plan and go back to the marketplace. He said historically, within two or three years, it has been demonstrated that a lot of the healthy risk has left these plans, leaving only the sicker people in the plan. The plan headcount is variable and can move back and forth based upon the viability of the plan. **Mr. Leavitt** noted several examples of past MEWAs and their experience within the last two or three years.

Mr. Elwood Kleaver was the next speaker. He stated that he is also the Vice President for the Idaho Association of Health Plans and was representing them at this meeting. He said he does not know much about the Gem Plan and found today's presentation helpful. Regarding the need to be able to transition into a regulated environment, **Mr. Kleaver** said that transition is a difficult time in any insurance company's development and if there is a time when they need to be monitored objectively by someone, that is the optimal time to do it. He said he has seen many companies get into difficulty at that point in time, particularly if they are having a period of

growth. He said what happens is that there is a lot of revenue coming in and the companies are "cash flush" and the expenses for the insured have not started coming in. Unless a company is diligent, it can think it is doing much better than it is. He said it is like a freight train that just keeps coming.

Mr. Kleaver said he was concerned about this but became more concerned when **Mr. Guthrie** said that the Gem Plan was going to have an actuarial report at the end of the year and look at the IBNRs. He said he does not know of a successful insurance company today that does not look at this multiple times each month because it is so significant. **Mr. Kleaver** said the fact that the Gem Plan has actuaries and consultants is fine, but he has seen many companies that have these people but they do not listen to them. Unless someone is overseeing what is being done, they could easily go down the wrong road. **Mr. Kleaver** noted that the problems of insurance companies being insolvent crosses all lines, including mutual companies, nonprofits, for profits, and even county health programs. It is just an issue of paying attention and making sure everything is being done correctly. He encouraged the Gem Plan and any MEWA to openly engage in being regulated, either by the Department or someone else. Without some form of regulation, it can be very dangerous.

Senator Cameron asked, from the day someone is insured, what the lag in time is until a company begins to pay claims for them. **Mr. Kleaver** said his company watches this very closely by looking at an incurred-to-receive basis. This means the company knows that the claim has been received. He said they receive the majority of their claims within the first month, but they can be paying claims up to 18 months out. **Ms. Taylor** said she would assume that this is true for Blue Cross as well and added that sometimes providers do not submit claims in a timely manner, so it could be a few months before the physician actually submits the claim.

Representative Henbest asked why a nonregulated public entity that is self-funded falls outside of regulation that others must meet. She said that since the Gem Plan is made up of Idaho counties within the state, it is not likely that they are going to leave the state. She commented that maybe some regulations would not be necessary for this group and that the proposed legislation seems to add additional regulations to MEWAs that do not make sense to her. **Senator Cameron** said the new legislation will still have to be reviewed in detail.

Ms. Taylor said this is being reviewed in terms of what the consumer needs for protection and the ability to go somewhere with complaints or problems. She said the playing field needs to be level and consumers need to know that they are fully protected.

Representative Henbest requested information regarding whether, since the Gem Plan is a public entity entrusted with public dollars to secure coverage for these employees, they need all the same regulations. She said she would also like to see a discussion of the proposed legislation. **Ms. Taylor** said this is why she added the third column of her chart. It shows that regulated self-funded plans do not follow all of the same regulations as Blue Cross or other regulated plans in Idaho, but in certain important areas they do have critical protections. **Mr. Kleaver** said this is still the business of insurance and certain rules need to be followed because there is no way to

tell whether county commissioners or a private company are standing behind it. It is important to build stability and confidence in the marketplace. He said other counties have gotten into trouble because they did not fully understand what they were doing in the very complicated business of insurance.

Senator Compton said he agrees that there needs to be some standard of regulation for these plans and that they need to report to someone. He said he would be disappointed if this proposed legislation does add additional requirement for MEWAs to comply with.

Senator Corder commented that medical services cost the same and asked how an insurance plan such as the Gem Plan can say they are more efficient than other companies.

Ms. Taylor said that part of the value of a regulated company is that they can do provider contracting that enables them to be more efficient and to provide the services at less cost.

Senator Cameron commented that he agreed with **Representative Henbest** and **Senator Compton** that there is a place for regulation and it needs to be decided what that is. In his opinion, neither the Task Force nor the Legislature wants to create a situation that causes county employees to be without coverage. At the same time, there are added protections needed.

Senator Stegner was introduced to give a report on the Mental Health Subcommittee meeting that was held on October 26, 2005. The minutes of this meeting are available at www.legislature.idaho.gov and also at the Legislative Services Office. He restated the priorities the subcommittee established and said the subcommittee plans to have one more meeting to finalize these items and prepare legislation to present to task force for consideration. Some of these priorities, in no particular order, include:

- Direct and authorize the regional mental health boards to develop mental health plans for the region.
- Increase the number of psychiatric beds, primarily through contracts with public and private hospitals.
- Propose that the mental health indigency costs that are currently being debated be clarified as either a state or county responsibility. (He said the subcommittee is going to recommend that the state share in those costs.)
- Suggest that Idaho reconsider the mental health insurance parity issue. Idaho is one of only two states without some type of mental health insurance parity.
- Improve the transparency of mental health sharing information throughout the correctional system.
- Ask for expanded assertive community treatment (ACT) teams.
- Support the expansion of mental health courts.
- Possible recommendation that the statutory diagnostic definitions for mental health for adults be broadened and expanded for Health and Welfare services.
- Improve school involvement and possibly focus on community resource workers.
- Involvement in the Millennium Fund allocation of money and how that might be a source

of funds for mental health infrastructure treatment and prevention.

The meeting was adjourned at 3:50 p.m. The next meeting of the Task Force was scheduled for November 30, 2005 at 9:00 in the JFAC room. The chairs indicated that proposed legislation would be presented at the next meeting for the Task Force to review.